Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

March 25, 2003

The Honorable William Thomas
Chairman, Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Thomas:

On March 20, 2003, the Subcommittee on Health ordered favorably reported to the full Committee H.R. 810, the "Medicare Regulatory and Contracting Reform Act of 2003," as amended, by voice vote.

The Subcommittee proposal would streamline regulatory bureaucracy for beneficiaries and providers, and reform Medicare's administrative contracting for the operations of Part A and Part B.

Transmitted herein, in accordance with Committee Rule 11, is a report containing a comparison with present law, a section-by-section analysis of the proposed changes, and a section-by-section justification.

Sincerely,

Nancy L. Johnson
Chairman

NLJ/dw

H.R. 810 - Medicare Regulatory and Contracting Reform Act of 2003
Committee on Ways and Means
Subcommittee on Health
Subcommittee Report on H.R. 810
The "Medicare Regulatory and Contracting Reform Act of 2003"

A. PURPOSE AND SUMMARY

Purpose

There are currently over 130,000 pages of regulations for the Medicare program. These regulations are often confusing, overly burdensome and can take away from providers' time with patients. They are also needed to assure payment for services rendered and to monitor compliance with the conditions of participation and other quality of care requirements.

The purpose of H.R. 810 is to streamline paperwork requirements under the Medicare program and communicate clearer instructions to providers of services and suppliers so that they may spend more time caring for patients. At the same time, the bill does not prevent or impede the ability of the Department of Health and Human Services to combat waste, fraud and abuse. It is also intended to reform the Medicare contracting process to make it more open by requiring competition.

Summary

Regulatory Reform. – This bill would provide protections for beneficiaries and providers by requiring new matter introduced in a final rule that is not a logical outgrowth of previously published material to be treated as a proposed regulation until there is public comment. It also prohibits retroactive application of regulations and policies. Finally, providers that rely on written, but erroneous guidance from the Secretary or its contractors shall not be subject to sanctions if they reasonably relied on such guidance.

Contracting Reform. – This bill would reform Medicare's contracting system for administrative functions by consolidating contracting functions for Part A and Part B, requiring competition among contractors, and providing for more flexibility for contractors.

Education and Outreach. – This bill would improve beneficiary and provider education and outreach by: requiring coordination of educational activities: providing incentives to improve contractor performance, requiring written responses within 45 days; providing a toll-free telephone number for questions about the program and outreach programs for beneficiaries and

small providers. It also establishes ombudsmen for beneficiaries and providers and a demonstration program to place Medicare staff in selected Social Security offices.

Appeals. – This bill would transfer responsibility for Medicare appeals from Social Security to the Department of Health and Human Services. The Administrative Law Judges would maintain their independence from the Centers for Medicare and Medicaid Services. It also establishes requirements for independence of the Qualified Independent Contractors by ensuring no conflicts of interest. Finally, beneficiaries would be provided with more information on the disposition of their cases.

Overpayment. – This bill establishes standards for prepayment review, audits and consent settlements; allows for hardship in the case of repayment of overpayments; and limits recoupments by the program until the first independent level of appeal – qualified independent contractors – is determined. It also allows for beneficiaries and physicians to ask for prior authorization for physician office services.

Miscellaneous and Technical Provisions. – This bill contains a number of provisions that would facilitate the introduction of new technology into the system. It also limits some information requests to providers or otherwise requires the Secretary to provide the information. It provides flexibility to hospice organizations in extraordinary circumstances.

Subcommittee Action

During the 107th Congress, the Subcommittee held two hearings on regulatory and contracting reform: March 15, 2001 and September 25th, 2001. After Subcommittee Chairman Johnson and Representative Stark introduced the "Medicare Regulatory Contracting Reform Act of 2001" (HR 2768) on August 2, the Committee favorably reported that bill October 4, 2001 on a voice vote. After conferring with the Energy and Commerce Committee, a revised version (HR 3391) was introduced and passed the House 408-0 on December 4, 2001. Most of the provisions in this bill were incorporated into the Medicare Modernization and Prescription Drug Act (HR 4954), which passed the House in June, 2002.

Action commenced on regulatory and contracting reform in the 108th Congress with the introduction of the Medicare Regulatory and Contracting Reform Act (HR 810) of 2003 by Chairman Johnson and Representative Stark on February 12. This bill is nearly identical to HR 3391 that passed the House in the 107th Congress. The Subcommittee on Health held a hearing on HR 810 on February 13th 2003, and heard testimony from CMS Administrator Tom Scully, Dr. Douglas Wood, Chairman of the Secretary's Advisory Committee on Regulatory Reform, and provider and beneficiary representatives.

On March 19, 2003, the Subcommittee on Health favorably reported on a voice vote to the full Committee H.R. 810 the "Medicare Regulatory and Contracting Reform Act of 2003." The major changes made in the Chairman's amendment in the nature of a substitute were to conform the liability for contractors to language negotiated by the Department of Justice, Office of Inspector General, CMS and contractors, and to delete obsolete provisions, which CMS is already undertaking administratively.

Section 1. Short Title; Amendments to Social Security Act; Table of Contents

Current Law. No provision.

Explanation of Provision. Except as otherwise specified, the provisions would amend or repeal a section or other provisions of the Social Security Act.

Effective Date. Upon enactment.

Section 2. Findings and Construction.

Current Law. No provision.

Explanation of Provision. Congress finds that the overwhelming numbers of providers are law-abiding and directs the Secretary to streamline Medicare's paperwork requirements so that time spent on patient care can increase.

None of the provisions shall be construed to (1) compromise the existing legal remedies for addressing Medicare fraud or abuse with respect to criminal prosecution, civil enforcement, or administrative remedies, including those established by the False Claims Act or (2) prevent the Department of Health and Human Services (HHS) from conducting its ongoing efforts to eliminate waste, fraud, and abuse in Medicare. Also, consolidation of Medicare's administrative contracting functions (as provided for in this bill) would not consolidate the Federal Hospital Insurance Trust Fund, which pays for Part A services and the Federal Supplementary Medical Insurance Trust fund, which pays for Part B services. The bill notes that this administrative consolidation of contracting functions does not reflect any position on that issue.

Effective Date. Upon enactment.

Reason for Change. The Committee is committed to extending needed regulatory relief to providers and suppliers while at the same time protecting taxpayers from waste, fraud and abuse.

Section 3. Definitions.

Current Law. No provision.

Explanation of Provision. The term, "supplier," means a physician, practitioner, facility or other nonprovider entity that furnishes Medicare items or services unless otherwise indicated. BIPA means the Medicare Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 and Secretary means the Secretary of Health And Human Services (HHS).

Effective Date. Upon enactment.

TITLE I - REGULATORY REFORM

Section 101. Issuance of Regulations.

(a) Limitation on New Matter in Final Regulations.

Current Law. No provision.

Explanation of Provision. A provision in a final regulation that is not a logical outgrowth of a previously published notice or proposed rulemaking or interim final rule would be treated as a proposed regulation and would not take effect without a separate public comment period followed by its publication as a final regulation.

Effective Date. Final regulations published on or after enactment.

Reason for Change. The provision ensures that interested parties will be given an opportunity to comment on issues addressed in regulations before they take effect. The Committee recognizes that proposed regulations for annual payment updates for providers and suppliers include proposed overall payment updates, and that specific payment amounts for specific codes or specific payment areas are not typically included until final rules. The Committee does not intend to change the requirements or application of the Administrative Procedures Act. It is the Committee's intent that if the Secretary publishes a final rulemaking document which includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking, such provision will not take effect until there is further opportunity for public comment and a publication of the provision again as a final regulation.

Section 102. Compliance with Changes in Regulations and Policies.

(a) No Retroactive Application of Substantive Changes.

Current Law. No provision.

Explanation of Provision. A substantive change in a regulatory or a subregulatory issuance would not be applied retroactively to items or services, unless the Secretary determines that retroactive application (1) would be necessary to comply with statutory requirements; or (2) would be beneficial to the public interest.

Effective Date. For substantive changes issued on or after enactment.

Reason for Change. This provision will ensure that Medicare's rules are not generally applied retroactively.

(b) Timeline for Compliance with Substantive Changes after Notice.

Current Law. No provision.

Explanation of Provision. A substantive change would not become effective before 30 days after the date the change is issued or published. The Secretary would be able to waive the 30-day period to comply with statutory requirements or if such waiver is in the public interest. If an earlier date is established, the Secretary would be required to include a brief explanation of such finding in the issuance or publication of the substantive change. No compliance action would be permitted against a provider or supplier for goods and services furnished before the effective date of the substantive change.

Effective Date. For compliance actions undertaken on or after enactment.

Reason for Change. This provision will ensure providers and suppliers have sufficient time to make any changes to systems needed to comply with changes in regulations.

(c) Reliance on Guidance

Current Law. No provision.

Explanation of Provision. A provider or supplier who reasonably relied on erroneous guidance would not be subject to any sanction or penalties, including repayment, provided the following conditions were met: (1) The provider or supplier follows written guidance (which may be transmitted electronically) provided by the Secretary or a Medicare contractor when furnishing an item or service and submitting a claim; (2) the Secretary finds that the circumstances relating to the furnished items and services have been accurately presented in writing to the contractor; and

(3) the guidance is inaccurate. This provision would not prevent recoupment or repayment (without additional penalty) if the overpayment were solely the result of a clerical or technical operational error.

Effective Date. Upon enactment, but would not apply to sanctions where notice was provided on or before enactment.

Reason for Change. This provision will ensure that providers and suppliers who, in good faith based on the information received from contractors will not be vulnerable to recovery if it turns out that the contractor was in error. Providers should be able to rely on the directions or guidance provided by their Medicare contractors.

Section 103. Reports and Studies Relating to Regulatory Reform.

Current Law. No provision.

Explanation of Provision. The legislation has two studies in this area. First, the Comptroller General of the United States (GAO) would be required to conduct a study to determine the appropriateness and feasibility of providing the authority to the Secretary to issue legally binding advisory opinions on the interpretation and application of Medicare regulations. The study would examine the appropriate time frame for issuing the decisions as well as the need for additional staff and funding. GAO would submit the study not later than one year after enactment.

Second, the Secretary would be required to report to Congress on the administration of the Medicare program and inconsistencies among existing Medicare statutory or regulatory provisions. The report would include (1) information from beneficiaries, providers, suppliers, Medicare Beneficiary and Provider Ombudsmen (established in Section 303 of this legislation), and Medicare contractors; (2) descriptions of efforts to reduce inconsistencies; and (3) recommendations from the Secretary for appropriate legislation or administrative actions. The report would be due no later than two years after enactment and every two years thereafter.

Effective Date. Upon enactment.

Reason for Change. The Committee is interested in receiving additional information regarding both advisory opinions and inconsistencies in Medicare regulations.

TITLE II - CONTRACTING REFORM

Section 201. Increased Flexibility in Medicare Administration.

(a) Consolidation and Flexibility in Medicare Administration.

Current Law. Section 1816 of the Social Security Act authorizes the Secretary to establish agreements with fiscal intermediaries nominated by different provider associations to make Medicare payments for health care services furnished by institutional providers. Section 1842 of the Act authorizes the Secretary to enter into contracts with health insurers (or carriers) to make Medicare payments to physicians, practitioners and other health care suppliers. Section 1834(a)(12) of the Act authorizes separate regional carriers for the payment of durable medical equipment (DME) claims. Section 1893 authorizes the Secretary to contract for certain program safeguard activities under the Medicare Integrity Program (MIP).

Certain terms and conditions of the contracting agreements for fiscal intermediaries and carriers are specified in the Medicare statute. Medicare regulations coupled with long-standing agency practices have further limited the way that contracts for claims administration services can be established. Specifically, the contracts are awarded without full and open competition; generally must cover the range of claims processing and related activities; cannot be terminated without cause and without the opportunity for a public hearing; and incorporate cost-based, not performance-based, reimbursement methods with no incentive bonuses.

Certain functions and responsibilities of the fiscal intermediaries and carriers are specified in the statute as well. The Secretary may not require that carriers or intermediaries match data obtained in its other activities with Medicare data in order to identify beneficiaries who have other insurance coverage as part of the Medicare Secondary Payer (MSP) program. With the exception of prior authorization of DME claims, an entity may not perform activities (or receive related payments) under a claims processing contract to the extent that the activities are carried out pursuant to a MIP contract. Performance standards with respect to the timeliness of reviews, fair hearings, reconsiderations and exemption decisions are established as well.

A Medicare contract with an intermediary or carrier may require any of its employees certifying or making payments provide a surety bond to the United States in an amount established by the Secretary. Neither the contractor nor the contractor's employee who certifies the amount of Medicare payments is liable for erroneous payments in the absence of gross negligence or intent to defraud the United States. Neither the contractor nor the contractor's employee who disburses payments is liable for erroneous payments in the absence of gross negligence or intent to defraud the United States, if such payments are based upon a voucher signed by the certifying employee.

Explanation of Provision. The legislation would add Section 1874A to the Social Security Act to permit the Secretary to enter into contracts with any entity to serve as a Medicare administrative contractor. These contractors would perform or secure the performance (through subcontracting)

of some or all of the following tasks: determine payment amounts; make payments; educate and assist beneficiaries; provide consultative services; communicate with providers and suppliers; educate and offer technical assistance to providers; and perform additional functions as necessary. An entity eligible to enter into a contract with respect to the performance of a particular function as an entity would (1) have demonstrated capability to carry out such function; (2) comply with conflict of interest standards that are generally applicable under Federal acquisition and procurement; (3) have sufficient assets to financially support the performance of such functions and (4) meet other requirements imposed by the Secretary. The claims processing jurisdiction of Medicare administrative contractor would be determined by the scope of the contract awarded to the entity. Specifically, the Medicare administrative contractor that would perform a particular function is the entity that has the contract to perform that function for any given beneficiary, any given provider or supplier, or class of same.

The Federal Acquisition Rules (FAR) would apply to Medicare administrative contracts except to the extent they are inconsistent with a specific Medicare requirement. The Secretary would be required to use competitive procedures when entering into a Medicare administrative contract and would take into account performance quality, price, and other factors. The Secretary would be able to renew a contract for up to five years without regard to statutory requirements concerning competitive contracting if the entity has met or exceeded specified performance standards. The Secretary would be able to transfer functions among contractors consistent with these provisions. The Secretary would be required to (1) ensure that performance quality is considered in such transfers and (2) provide notice of such transfer (in the *Federal Register* or otherwise) including a description of the transferred functions, the affected providers and suppliers, and includes contractor contact information.

The Secretary would be required to (1) provide incentives for the Medicare administrative contractors to provide efficient, high-quality services; and (2) develop performance standards with respect to each of the payment, provider service, and beneficiary service functions required of the contractors. In developing the performance standards, the Secretary would be able to consult with providers and suppliers, organizations representing Medicare beneficiaries, and Medicare contractors. In developing the performance requirements for Medicare administrative contractors, the Secretary may include satisfaction of beneficiaries as a standard for measuring performance. The Secretary would be required to contract only with those entities that will (1) perform efficiently and effectively; (2) meet standards for financial responsibility, legal authority and service quality among other pertinent matters; (3) agree to furnish timely and necessary data; and (4) maintain and provide access to necessary records and data.

The performance requirements would be (1) set forth in the contract between the Secretary and the appropriate Medicare contractor; (2) used to evaluate contractor performance; and (3)

consistent with the contract's written statement of work. The statement of work and contract are public documents. A Medicare administrative contract would contain provisions deemed necessary by the Secretary and may provide for advances of Medicare funds for the purposes of making payments to providers and suppliers. In developing contract performance requirements for Medicare administrative contractors, the Secretary would be required to consider the inclusion of the existing standards in effect for timeliness of reviews, reconsiderations and exemption decisions.

The existing MSP provision would apply: the Secretary would not be able to require contractors to match their data with Medicare data for the purposes of the identifying beneficiaries with other insurance coverage. The Secretary would assure that the activities of the Medicare administrative contractors do not duplicate the Medicare Integrity Program (MIP) functions except with respect to the prior authorization of durable medical equipment. An entity with a MIP contract would not be treated as a Medicare administrative contractor simply because it has a MIP contract.

A Medicare administrative contractor and any of its employees certifying or disbursing payments may be required to provide a surety bond to the United States in an amount established by the Secretary. It is the intent of Congress that the definition of a surety bond in this instance includes fidelity bonds and the Secretary has the authority to request fidelity bonds.

A Medicare administrative contractor, certifying officer, or disbursing officer shall not be liable for erroneous payments in the absence of reckless disregard or intent to defraud the United States. While Medicare administrative contractors are not liable for inadvertent billing errors, as in the past, they are liable for all penalties and damages resulting from reckless disregard of their obligations under their Medicare administrative contracts or intent to defraud the United States. The “reckless disregard” standard is the same as that under the False Claims Act which has been used effectively by whistleblowers and the Department of Justice to uncover and penalize fraud against the Medicare program by some fiscal intermediaries and carriers. This “reckless disregard” standard, which does not require proof of specific intent to defraud, is designed to balance the practical need to shelter Medicare Administrative Contractors from frivolous civil litigation by disgruntled providers or beneficiaries with the Medicare program’s interest in protecting itself from contractor fraud. This section makes it clear that the False Claims Act continues, as in the past, to remain available as a remedy for fraud against Medicare by contractors, and that, as in the past, the damages and penalties which the Medicare program is entitled to recover from fraudulent contractors include not just administrative payments but also the affected payments from the Medicare trust funds.

The Secretary would be able to indemnify a Medicare administrative contractor, subcontractor, or employee who is made a party to any judicial or administrative proceeding arising from the claims administration process to an appropriate extent as determined by the Secretary and

specified in the contract. Indemnification in this case may include payment of judgments, certain settlements, awards and costs (including reasonable legal expenses). Settlement proposals would not be negotiated or compromised without prior written approval by the Secretary. The Secretary would not be able to provide any indemnification if the liability arises directly from conduct that is determined in the proceeding or by the Secretary to be criminal in nature or fraudulent. If indemnification is provided before such determination is made that such costs arose directly from such conduct, the contractor would reimburse the Secretary for these costs. The provisions would not change common law immunity available to the Medicare contractor or other party, or permit the payment of costs not otherwise allowable, reasonable or allocable under the Federal Acquisition Regulation.

Effective Date. See subsection (d).

Reason for Change. Medicare's current contracting represents an antiquated, inefficient, and closed system based on cozy relationships between the government, contractors and providers.

Medicare contracting is antiquated because contractors may not provide service for the entire Medicare program, or particular functions within the program; rather Fiscal Intermediaries administer claims for facilities and carriers administer claims for all other providers. It has failed to keep pace with integrated claims administration practices in the private sector.

Medicare contracting is inefficient because Medicare does not award contracts for Fiscal Intermediaries through competitive procedures, but rather on provider nomination.

Medicare contracting is a closed system. All but one of the contractors today have been with Medicare since the program's inception 38 years ago, and only insurers can provide contracting services under current law.

This provision permits greater flexibility in contracting for administrative services between the Secretary and the Medicare contractors (entities that process claims under Part A and Part B of the Medicare program), including the flexibility to separately contract for all or parts of the contractor functions. The Secretary also may contract with a wider range of entities, so that the most efficient and effective contractor can be selected.

These amendments require the Secretary to contract competitively at least once every five years for the administration of benefits under Parts A and B. In conjunction with the elimination of cost contracts, it is intended to create incentives for improved service to beneficiaries and to providers of services and suppliers.

(b) Conforming Amendments to Section 1816 (Relating to Fiscal Intermediaries).

Current Law. Section 1816 of the Social Security Act establishes the provider nomination process, the contracting specifications, and performance standards for fiscal intermediaries that currently contract with Medicare to process claims and perform other related administrative activities for institutional providers.

Explanation of Provision. The provisions establish that the activities of fiscal intermediaries in administering Medicare would be conducted through contracts with Medicare administrative contractors as set forth in subsection (a). The provider nomination process and contracting specifications would be repealed. Certain performance standards with respect to the processing of clean claims would be retained. Certain annual reporting requirements concerning the contractor's overpayment recovery efforts would be retained.

Effective Date. See subsection (d).

Reason for Change. These amendments provide a basis for a unified contracting system for the administration of Parts A and B, identical to the recent Congressionally mandated structure of the Medicare Integrity Program contractors. Consolidation of contracting duties as set forth in this legislation does not constitute consolidation of the Hospital Insurance and Medical Supplementary Insurance Trust Funds, or reflect any position on that issue. In addition, the elimination of provider nomination, which hospitals have rarely been allowed to exercise in recent years, is essential for bringing full and open competition into the contracting functions of the Medicare program.

(c) Conforming Amendments to Section 1842 (Relating to Carriers).

Current Law. Section 1842 of the Social Security Act establishes that carriers will be used to administer certain Medicare benefits as well as the contracting requirements and certain performance standards for those activities.

Explanation of Provision. The provisions would establish that the activities of carriers administering Medicare would be conducted through contracts with Medicare administrative contractors as set forth in subsection (a). Certain instructions including those pertaining to nursing facilities payments, claims assignment, physician participation, overpayment recoveries and billing by suppliers would be retained. Certain performance standards with respect to the processing of clean claims would be retained. Contracting specifications and other conforming changes would be established. The Secretary, not the contractor, would be responsible for taking necessary actions to assure that reasonable payments are made, for those made on both a cost and charge basis. The Secretary, not the contractor, would be responsible for maintaining a toll-free telephone number for beneficiaries to obtain information on participating suppliers. Since the

Carrier fair hearing requirement were eliminated in BIPA, the requirements for the hearing are eliminated to conform with existing law. Certain annual reporting requirements concerning the contractor's overpayment recovery efforts would be retained.

The Committee directs the Secretary's attention to the provision of the Balanced Budget Act of 1997 requiring CMS to designate no more than five regional carriers to process laboratory claims. This provision was passed in order to streamline the processing of laboratory claims and was to be implemented by July 1, 1999, but CMS has taken no action to date. In consultation with the clinical laboratory industry, CMS may consider other potential solutions, including the designation of a single contractor to process all claims of laboratory entities operating in more than one state. CMS is directed to report back to the Committee on Ways and Means and the Committee on Energy and Commerce within three months detailing the action it has taken to implement this directive.

Effective Date. See subsection (d).

Reason for Change. The provision establishes a basis for a unified contracting system, identical to the structure implemented for the Medicare Integrity Program (MIP) contractors. It is important to note, however, that consolidation of contracting duties as set forth in this legislation does not constitute consolidation of the Hospital Insurance and Medical Supplementary Insurance Trust Funds, or reflect any position on that issue. In addition, the Secretary would have the flexibility to choose the best contractor(s) to provide telephone information on suppliers which is intended to reduce administrative costs and improve quality. Since the carrier fair hearing requirement was eliminated in previous legislation, the requirements for the hearing are eliminated in order to conform with existing law.

(d) Effective Date; Transition Rule.

Current Law. No provision.

Explanation of Provision. Except as otherwise provided in this subsection, the provisions in this section would be effective October 1, 2005. The Secretary would be authorized to take necessary actions prior to that date in order to implement these amendments on a timely basis to transition from the contracts established under sections 1816 and 1842 of the Social Security Act to those established under the new section 1874A created by this legislation. The transition would be consistent with the requirement that the administrative contracts be competitively bid by October 1, 2010. The requirement that MIP contracts be awarded on a competitive basis would continue to apply and would not be affected by the provisions in this section. The MIP contracting exception that allows agreements according to current law would be deemed to be a contract established under the new authority of 1874A and would continue existing activities. The

Secretary has the authority to recognize the appropriate termination costs of the current contractors during the transition from cost contracts to competitively bid contracts.

(e) References.

Current Law. No provision.

Explanation of Provision. After this section becomes effective, any reference to fiscal intermediary or carrier would be considered a reference to the appropriate Medicare administrative contractor.

(f) Reports on Implementation.

Current Law. No provision.

Explanation of Provision. The Secretary would submit an implementation plan to Congress and GAO no later than October 1, 2004. GAO would evaluate the plan and include appropriate recommendations no later than six months after the plan is received. No later than October 1, 2008, the Secretary would be required to submit a status report to Congress including (1) the number of contracts that have been competitively bid; (2) the distribution of functions among contracts and contractors; (3) a timeline for complete transition to full competition; and (4) a detailed description of changes to contractor oversight and management.

Effective Dates. Upon enactment.

Section 202. Requirements for Information Security.

Current Law. No provision.

Explanation of Provision. Medicare administrative contractors that determine and make payments would be required to implement a contractor-wide information security program that meets the requirements imposed on Federal agencies to ensure the security, integrity, confidentiality, authenticity, and availability of operational data and systems supporting operations. An annual audit of the information security at each Medicare administrative contractor: (1) would be performed by an independent entity that meets the independence requirements specified by the Office of the Inspector General (OIG) in HHS; and (2) would test the effectiveness of the information security techniques for an appropriate subset of the contractor's systems. An audit of new contractors (those that have not been fiscal intermediaries or carriers) would be required prior to the start of their performing Medicare payment functions.

An audit of existing contractors (those that are now fiscal intermediaries and carriers) would be required to be completed within one year from enactment. The results of the audits would be reported promptly to the OIG which will submit a report annually to Congress. These provisions would be equally applicable to fiscal intermediaries and carriers as to Medicare administrative contractors.

Effective Date. Upon enactment.

Reason for Change. The increased reliance by the Federal government on the Internet and related telecommunications technologies has resulted in enhanced inter-connectivity and interdependencies associated with Federal computer systems and between federal and private computer systems. Over the past several years, this inter-connectivity or "networking" has resulted in increased security vulnerabilities that have put at greater risk computer systems and data that are critical to ensuring national and economic security and public health and welfare, including sensitive, non-public information that is collected and maintained by CMS and its business partners.

Investigations have revealed significant security weaknesses, which the agency has been working to address. Some of the computer security concerns identified include weak password management, inadequate access controls, excessive user privileges, improper network configurations, and inadequate testing of critical systems. In addition, the OIG conducted assessments of financial controls - including electronic data processing controls - at CMS and its major Medicare contractors, and, in every year since 1997, the OIG has identified computer security controls to be a material weakness at both CMS and the Medicare contractors reviewed.

Section 202 is intended to assist CMS in identifying and working with contractors to address potential security deficiencies in order to ensure that sensitive, non-public information related to the processing of Medicare claims is adequately secure from unauthorized access, misuse, or destruction.

TITLE III - EDUCATION AND OUTREACH IMPROVEMENTS

Section 301. Provider Education and Technical Assistance.

(a) Coordination of Education Funding.

Current Law. Medicare's provider education activities are funded through the program management appropriation and through the Education and Training component of the Medicare Integrity Program (MIP). Both claims processing contractors (fiscal intermediaries and carriers) and MIP contractors may undertake provider education activities.

Explanation of Provision. The provision would add Section 1889 to the Social Security Act which would require the Secretary to (1) coordinate the educational activities provided through the Medicare administrative and MIP contractors and (2) to submit an evaluation to Congress, no later than October 1, 2002, on actions taken to coordinate the funding of provider education.

Effective Date. Upon enactment.

Reason for Change. This provision is intended to ensure that federal spending on provider education is coordinated and used as efficiently as possible to maximize the value obtained from the investment. It is not intended to change the proportion of Medicare Integrity Program funds spent on provider education.

(b) Incentives to Improve Contractor Performance.

Current Law. No specific statutory provision. Since FY1996, as part of the audit required by the Chief Financial Officers Act, an estimate of improper payments in Medicare fee-for-service has been established annually. As a recent initiative, CMS is implementing a comprehensive error rate testing program to produce national, contractor specific, benefit category specific and provider specific paid claim error rates.

Explanation of Provision. The Secretary would be required to use the specific claims payment error rates or similar methodology at each Medicare administrative contractor to provide incentives for such contractors to effectively educate providers on proper claims procedures. This methodology would apply to existing fiscal intermediaries and carriers in the same manner as it applies to Medicare administrative contractors. No later than October 1, 2004, GAO would submit to Congress and to the Secretary a report on the adequacy of the methodology, including recommendations as appropriate. No later than October 1, 2004, the Secretary would be required to report to Congress on (1) the use of the claims error rate methodology in assessing the effectiveness of contractors' provider education and outreach programs and (2) whether

methodology should be used as a basis to pay contractors' performance bonuses.

Effective Date. As specified.

Reason for Change. This provision would ensure that the Department monitors contractor performance for claims payment error rates, and it would identify best practices for provider education - all with the goal of reducing payment errors and helping providers and suppliers better comply with program requirements. It is the Committee's intent that, in consultation with representatives of providers and suppliers, the Secretary shall identify and encourage best practices developed by contractors for educating providers and suppliers.

(c) Provision of Access to and Prompt Responses from Medicare Administrative Contractors.

Current Law. No specific statutory provision. Statutory provisions generally instruct carriers to assist providers and others who furnish services in developing procedures relating to utilization practices and to serve as a channel of communication relating information on program administration. Fiscal intermediaries are generally instructed to (1) provide consultative services to institutions and other agencies to enable them to establish and maintain fiscal records necessary for program participation and payment and (2) serve as a center for any information as well as a channel for communication with providers.

Explanation of Provision. The Secretary would be required to develop a communication strategy with beneficiaries, providers and suppliers. Each Medicare administrative contractor would be required to (1) provide general written responses (which may be through electronic transmission) in a clear, concise and accurate manner to written inquiries from beneficiaries, providers and suppliers within 45 business days; (2) provide a toll-free telephone number where these interested parties may obtain billing, coding, claims, coverage and other appropriate Medicare information; (3) maintain a system for identifying which employee provided both the written and oral information; and (4) monitor the accuracy, consistency, and timeliness of the information provided. The Secretary would be required to establish and make public the standards used to monitor the accuracy, consistency, and timeliness of information provided in response to written and telephone inquiries. The standards would be developed in consultation with provider, supplier, and beneficiary organizations and would be consistent with the contractors' performance requirements. The Secretary would be able to directly monitor the quality of the information so provided. These provisions would also apply to existing fiscal intermediaries and carriers.

Effective Date. By October 1, 2004.

Reason for Change. This provision is intended to improve contractor accountability to make contractors more responsive to providers and suppliers, and to increase the accuracy, timeliness

and reliability of the information provided in response to the questions received.

(d) Improved Provider Education and Training.

Current Law. In FY2000, $54.8 million was spent on provider education and training activities: about $43 million came from the program management appropriation and about $12 million came from the Provider Education and Training component of MIP. In FY2001, about $57.3 million was budgeted for these activities.

Explanation of Provision. The provisions would authorize $25 million in Medicare appropriations in FY2005 and FY2006 and such funds as necessary in subsequent years to increase provider education and training and to improve the accuracy and quality of contractor responses. The Committee intends for this amount to be provided in addition to current funding levels. Starting on October 1, 2004, the contractors' training activities would accommodate the special needs of small providers and suppliers. The provisions define a small provider as an institution with fewer than 25 full-time equivalents (FTEs) and a non-facility based provider or supplier with fewer than 10 FTEs.

Effective Date. Upon enactment and as specified.

Reason for Change. This provision acknowledges that contractors are being instructed to significantly improve their provider education and training efforts, and accordingly authorizes new funds to be available for those purposes.

(e) Requirement to Maintain Internet Sites.

Current Law. No provision.

Explanation of Provision. The Secretary and each contractor would be required to maintain an Internet site that provides answers to frequently asked questions in an easily accessible format as well as other materials published by the contractor.

Effective Date. By October 1, 2004.

Reason for Change. This provision will facilitate greater ease of provider and supplier access to information provided by Medicare's contractors.

(f) Additional Provider Education Provisions.

Current Law. No provision.

Explanation of Provision. A Medicare contractor would not be able to use attendance records at educational programs or information gathered during these programs to select or track candidates for audit or prepayment review. Nothing in the proposed legislation would require Medicare administrative contractors to disclose information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

Effective date. Upon enactment.

Reason for Change. This provision addresses a concern raised by providers and suppliers that their participation in educational forums has been used to trigger audits. Participation in educational forums should be encouraged not discouraged.

Nothing in this section or section 1893(g) shall be construed as preventing the disclosure by a Medicare contractor of information on attendance at education activities for law enforcement purposes. Nothing in this section or section 1893(g) shall be construed as providing for the disclosure by a Medicare contractor of the claims processing screens or computer edits used for identifying claims that will be subject to review.

Section 302. Small Provider Technical Assistance Demonstration Program.

Current Law. No provision.

Explanation of Provision. The Secretary would be required to establish a demonstration program and contract with qualified entities to offer technical assistance, when requested and on a voluntary basis, to small providers or suppliers. Small providers and suppliers would be those institutional providers with less than 25 full-time equivalents (FTEs) or suppliers with less than 10 FTEs. Technical assistance would include direct, in-person examination of billing systems and internal controls by qualified entities such as peer review organizations or other entities. In awarding these contracts, the Secretary would be required to consider any prior investigations of the entity's work by the Office of the Inspector General (OIG) in HHS or the GAO. Participating providers and suppliers would be required to pay an amount estimated and disclosed in advance that would equal 25 percent of the cost of the technical assistance they received. Absent indications of fraud, errors found in the review would not be subject to recovery if the problem is corrected within 30 days of the on-site visit and remains corrected for an appropriate period. However, this protection would only apply to claims filed as part of the demonstration project, would last only for the duration of the project and only as long as the provider or supplier was participating in the project. GAO, in consultation with the OIG, would be required to evaluate and provide recommendations on the continuation of the demonstration project no later than two

years after its implementation. The evaluation would include a determination of whether claims error rates were reduced for providers and suppliers who participated in the program. The provision would authorize $1 million in FY2005 and $6 million in FY2006 of appropriations from the Medicare Trust Funds to carry out demonstration project.

Effective Date. Upon enactment.

Reason for Change. Many large providers and suppliers have contracts with private consulting firms to help them navigate their interactions with the Medicare program. This type of assistance can be prohibitively expensive for small providers and suppliers - but they are also required to comply with complex program rules and regulations. This provision creates a new demonstration program to facilitate small provider and supplier access to expert technical assistance. The demonstration will also test whether encouraging technical assistance on the front end to help providers and suppliers play by the rules can save the program money in the long term by promoting greater program compliance.

Section 303. Medicare Provider Ombudsman; Medicare Beneficiary Ombudsman.

(a) Medicare Provider Ombudsman.

Current Law. No provision.

Explanation of Provision. The Secretary would be required to appoint a Medicare Provider Ombudsman within HHS to (1) to resolve unclear guidance and provide confidential assistance to providers and suppliers regarding complaints or questions about the Medicare program including peer review and administrative requirements; and (2) recommend changes to improve program administration. The Ombudsman would not advocate any increases in payments or expanded coverage, but would identify issues and problems in current payment and coverage policies.

Effective Date. One year after enactment.

Reason for Change. Providers are currently confronted with a morass of bureaucracy and regulation, with no clear individual to assist them. The new ombudsman will help providers navigate Medicare's complicated rules and regulations.

The Medicare Provider Ombudsman shall make recommendations to the Secretary concerning how to respond to recurring patterns of confusion in the Medicare program. Such a recommendation may include calling for the suspension of the imposition of provider sanctions (except those sanctions relating to the quality of care) where there is widespread confusion in program administration. Nothing in this section shall be construed as allowing for the suspension

of provider sanctions relating to the quality of care, regardless of whether widespread confusion in the Medicare program exists.

(b) Medicare Beneficiary Ombudsman.

Current Law. No provision.

Explanation of Provision. The Secretary would be required to appoint a Medicare Beneficiary Ombudsman within HHS from individuals with health care expertise, advocacy, and education of Medicare beneficiaries. The ombudsman would (1) receive complaints, grievances, and requests for information from Medicare beneficiaries; (2) provide assistance with respect to those complaints, grievances and requests, including assistance to beneficiaries who appeal claims determinations or those affected by the decisions of Medicare+Choice organizations to leave Medicare; and (3) submit an annual report to Congress and the Secretary describing activities and recommending changes to improve program administration. The Ombudsman would not advocate any increases in payments or expanded coverage, but would identify issues and problems in current payment and coverage policies.

To the extent possible, the Beneficiary Ombudsman would work with the Health Insurance and Assistance Counseling Programs authorized under Section 4360 of OBRA 1990, to facilitate the provision of information to Medicare beneficiaries regarding Medicare+Choice plans and any changes related to those plans. In addition, nothing in this section would preclude further collaboration, as appropriate, between the Beneficiary Ombudsman and these programs.

Effective Date. Once year after enactment.

Reason for Change. Beneficiaries confront a morass of bureaucracy and regulation, with no clear individual to assist them. This new ombudsman will help beneficiaries navigate Medicare's complicated rules and regulations.

(c) Funding.

Current Law. No provision

Explanation of Provision. The provision would authorize appropriations of necessary sums in FY2004 and subsequently from the appropriate Medicare Trust Funds for the Ombudsman programs.

Effective Date. Upon enactment.

Reason for Change. The Committee acknowledges that implementing these new functions will have a cost and accordingly authorize necessary appropriations.

(d) Use of Central Toll Free Number (1-800 MEDICARE).

Current Law. The Secretary is required to prepare and distribute an annual notice explaining Medicare benefits and limitations to coverage to Medicare beneficiaries. The Secretary is also required to provide information via a toll-free telephone number.

Explanation of Provision. The Secretary would be required to establish a toll-free number (1-800-MEDICARE) which will transfer individuals with questions or seeking help to the appropriate entities. The transfer would occur with no charge. This toll-free number would be the general information and assistance number listed on the annual notice provided to beneficiaries. GAO would be required to (1) monitor the adequacy, accuracy, and consistency of the information provided to Medicare beneficiaries through the toll-free 1-800 MEDICARE number and (2) examine the education and training of those providing the information through the toll-free number. GAO would be required to submit a report to Congress no later than one year from enactment. This toll-free number is intended to supplement, not replace, information and assistance available through non-federal sources. For example, contact information for the State Health Insurance Assistance Programs (SHIPs) should still be listed in the beneficiary handbook.

Effective Date. Upon enactment.

Reason for Change. The beneficiary handbook currently provides many pages of phone numbers, which can be very confusing for beneficiaries, rather than a single number that then can triage and transfer beneficiaries to the appropriate person or entity. This provision will promote better access to information for beneficiaries.

Section 304. Beneficiary Outreach Demonstration Program.

Current Law. No provision.

Explanation of Provision. The Secretary would be required to establish a 3-year demonstration project where Medicare specialists who are HHS employees are placed in at least six SSA offices to advise and assist Medicare beneficiaries. The SSA offices would be those with a high-volume of visits by Medicare beneficiaries; at least two of which would be in rural areas. In the rural SSA offices, the Secretary would provide for the Medicare specialists to travel among local offices on a scheduled basis. The Secretary would be required to (1) evaluate the project with respect to beneficiary utilization, beneficiary satisfaction, and cost-effectiveness and (2) recommend whether the demonstration should be expanded and made permanent.

Effective Date. Upon enactment.

Reason for Change. This provision makes Medicare experts available in six Social Security Administration offices to assist beneficiaries and answer their questions. The demonstration will test whether such outsourced Medicare specialists improve beneficiary understanding of the program and beneficiary satisfaction.

Section 305. Notification about Skilled Nursing Facility Benefits.

Current Law. No provision.

Explanation of Provision. The Secretary would be required to provide beneficiaries with information about the remaining number of days of skilled nursing facility coverage.

Effective Date. For notices provided during calendar quarters beginning more than six months after enactment.

Reason for Change. Beneficiaries are not always aware that their Medicare coverage is running out, and may need time to arrange alternate financing for continued skilled nursing facility care. This provision will provide beneficiaries with advance notice of the expiration of their skilled nursing benefit so that they have time to make arrangements without disruptions in care.

Section 306. Information on Medicare-Certified Skilled Nursing Facilities in Hospital Discharge Plans.

Current Law. No provision.

Explanation of Provision. The Secretary would make publicly available information that enables hospital discharge planners, Medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in Medicare.

Hospital discharge plans would be required to identify, for individuals who are likely to need post-hospital extended care services, the availability of Medicare-certified skilled nursing facilities that serve the area in which the patient resides.

Effective Date. Not later than 6 months after the Secretary provides for the availability of information needed for discharge plans.

Reason for Change. The Committee has received reports of beneficiaries being discharged to

non-Medicare skilled nursing facilities or beds. This provision is intended to assure that beneficiaries are given information during discharge planning about Medicare participating facilities. Thus, this provision would ensure that beneficiaries who need post acute care are notified about the availability of Medicare participating skilled nursing facilities in the area.

TITLE IV - APPEALS AND RECOVERY

Section 401. Transfer of Responsibility for Medicare Appeals.

Current Law. Medicare beneficiaries and, in certain circumstances, providers and suppliers of health care services may appeal claims that are denied or payments that are reduced. Section 1869 of the Social Security Act, which covers the Medicare claims appeals process, was amended by BIPA in its entirety, but the BIPA provisions are not yet effective. Generally, parties who have been denied coverage of an item or service have the right to appeal that decision through a series of administrative appeals and then into federal district court if the amounts of disputed claims in question meet certain thresholds at each step of the appeals process. A hearing by an administrative law judge (ALJ) in the Social Security Administration (SSA) with review by the Department Appeals Board (DAB) is a component of the administrative appeals process.

Explanation of Provision. By October 1, 2004, the Commissioner of SSA and the Secretary would develop a plan to transfer the functions of the administrative law judges (ALJs) who are responsible for hearing Medicare and Medicare related cases from SSA to HHS. The plan would be transmitted to Congress and GAO no later than October 1, 2004. The GAO would evaluate the plan and submit a report to Congress within six months. The Secretary and the Commissioner of SSA would implement the transition plan and transfer the ALJ functions no earlier than July 1, 2005 and no later than October 1, 2005. The Secretary would (1) assure the ALJ's independence from the Centers of Medicare and Medicaid Services (CMS) by placing the ALJs in an administrative office that is organizationally and functionally separate from CMS; and (2) locate the ALJs with an appropriate geographic distribution to ensure access. Subject to appropriations, the Secretary would be permitted to hire ALJs and support staff with priority given to ALJs with experience in handling Medicare appeals. Amounts previously paid to SSA for the ALJs performing the ALJ functions would be payable to the Secretary for the transferred functions. The Secretary would be permitted to enter into arrangements with SSA to share office space, support staff, and other resources with appropriate reimbursement from the Medicare trust funds. Increased appropriations would be permitted to increase the number of ALJs and support staff; improve education and training for ALJs and their staff; and increase DAB staff.

Effective Date. Upon enactment.

Reason for Change. The Office of Inspector General has identified moving the functions of the Medicare Administrative Law Judges to the Department of Health and Human Services as an important priority in improving the appeals system. This provision makes that transition and increases the emphasis on providing training Administrative Law Judges and their staffs to increase their expertise in Medicare's rules and regulations. The SSA Commissioner and the Secretary are instructed to work together on the transition plans in order to assure that the transition does not adversely affect the SSA ALJ appeals system. The Committee objects to recent proposals to locate the ALJs in CMS.

The transition plan shall include information on the following:

- Workload - The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes;
- Cost Projections - Funding levels required for fiscal year 2004 and subsequent fiscal years under this subsection to hear such cases in a timely manner;
- Transition Timetable - A timetable for the transition;
- Regulations - The establishment of specific regulations to govern the appeals process;
- Case Tracking - The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the Medicare program;
- Feasibility of Precedential Authority - The feasibility of developing a process to give binding, precedential authority to decisions of the Departmental Appeals Board in the Department of Health and Human Services that address broad legal issues; and,
- Access to Administrative Law Judges - The feasibility of filing appeals with administrative law judges electronically, and the feasibility of conducting hearings using tele- or video-conference technologies.

Section 402. Process for Expedited Access to Judicial Review

(a) In General.

Current Law. Section 521 of BIPA (which is not yet implemented) amends Section 1869 to establish deadlines for filing appeals and for making decisions in the Medicare appeals process. Generally, an initial determination is to be completed no later than 45 days from the date a claim for benefits is received; an individual dissatisfied with an initial determination is entitled to a redetermination by a carrier or fiscal intermediary if requested within 120 days of the determination date. The redetermination is to be completed no later than 30 days from the request date. The Secretary may reopen or revise any initial determination or reconsidered determination

under guidelines established by regulation.

An individual dissatisfied with the redetermination is entitled to reconsideration by a qualified independent contractor (QIC) if the request is initiated within 180 days of the notice of the adverse redetermination. With certain exceptions, a QIC reconsideration decision is to be completed within 30 days from the date a timely request has been filed. After a QIC's reconsideration, if the remaining contested amount is greater than $100, an individual is entitled to a hearing by an administrative law judge and then a review by the DAB. Both the ALJ hearing and the DAB review are to be completed within 90 days of a timely filed request for such an action.

If the dispute is not satisfactorily resolved and the contested amounts are greater than $1,000, the individual is entitled to judicial review of the decision. Under certain circumstances, a beneficiary is entitled to an expedited determination with accelerated deadlines. BIPA also provides for an expedited hearing under Section 1869, where the moving party alleges that no material issues of fact are in dispute; the Secretary makes an expedited determination as to whether any such facts are in dispute and, if not, renders a decision expeditiously.

Explanation of Provision. The Secretary would establish an appeals process for a provider, supplier, or beneficiary that permits access to judicial review when a review panel determines that no entity in the administrative appeals process has authority to decide the question of law or regulation in controversy and where material facts are not in dispute. The appellant would be able to make such request only once with respect to a question of law or regulation for a specific dispute. If the appellant requests this determination and submits appropriate supporting documentation, the review panel would make this determination in writing no later than 60 days after the receiving the request. A review panel would consist of a panel of three members who are ALJs, members of the DAB, or qualified individuals associated with a QIC or other independent entity designated by the Secretary to make these determinations. The determination by the review panel would be considered a final decision and not subject to review by the Secretary. Given such a determination or a failure to make the determination within the 60-day deadline, the appellant would be able to request judicial review before a civil court. The filing deadline for this civil action would be within 60 days of the determination or within 60 days of the end of the deadline to make such determination. The venue for judicial review would be the U.S. District Court where the appellant is located, or where the greatest number of appellants are located, or in the district court for the District of Columbia. The amount in controversy would be subject to annual interest beginning on the first day of the first month beginning after the 60-day deadline for filing. Interest would be equal to the rate of interest on obligations issued for purchase by the Medicare trust funds effective for the month that the civil action is authorized to commence. The interest payments would not be deemed to be Medicare reimbursement.

Effective Date. See section (c).

(b) Application to Provider Agreement Determinations.

Current Law. Section 1866(h) of the Social Security Act provides for a hearing and for judicial review of that hearing for any institution or agency dissatisfied with a determination that it is not a provider (or that it can no longer be a provider).

Explanation of Provision. An agency or institution's appeal concerning program participation under Section 1866 would have access to expedited judicial review under Section 1869 provisions. This provision would not be construed to affect remedies applied to assure quality of care in skilled nursing facilities (under Section 1819) while such appeals are pending.

(c) Effective Date.

Explanation of Provision. Amendments in the section would apply to appeals filed on or after October 1, 2004.

Reason for Change. The provisions in 402 (a-c) on expedited access to judicial review ensure that if a review board certifies that there are no material facts in dispute and that the appeals process does not have authority to resolve the question at issue, the provider, supplier, or beneficiary may take their case to court in an expedited manner. This will facilitate more prompt resolution of challenges to the underlying validity of CMS regulations and determinations. To the extent that any part of an appeal poses a factual dispute that is being adjudicated before an administrative tribunal, this provision would not authorize the severance of the legal issues from the underlying factual dispute.

(d) Expedited Review of Certain Provider Agreement Determinations.

Current Law. No provision.

Explanation of Provision. The Secretary would develop and implement a process under 1866(h) to expedite provider agreement determinations including those instances where participation is terminated or other sanctions (including denials of new admissions or appointment of temporary management) against skilled nursing facilities have been imposed. Priority would be given to termination of provider agreements. Increased appropriations from the Medicare trust funds in FY2005 and subsequently would be authorized in order to (1) reduce the average time for administrative determinations on provider participation appeals by 50 percent; (2) increase the number of ALJs and their staff; and (3) educate the ALJs and their staff on long term care issues.

Effective Date. Upon enactment.

Reason for Change. Given the disruption to beneficiaries if a facility is closed, this provides for an expedited appeal concerning a termination from Medicare.

Section 403. Revisions to Medicare Appeals Process.

(a) Requiring Full and Early Presentation of Evidence.

Current Law. No provision.

Explanation of Provision. A provider or supplier would not be able to introduce evidence that was not presented at reconsideration conducted by the QIC unless a good cause precluded its introduction at or before that reconsideration.

Effective Date. On or before October 1, 2004.

Reason for Change. The Office of Inspector General identified this change as a priority to promote more expeditious resolution of appeals of denied claims. This provision requires prompt introduction of evidence relevant to a provider appeal. When deciding whether there is good cause to introduce new evidence, the adjudicator should ensure, after consideration of the totality of the circumstances, that disallowing the introduction of such new evidence would unfairly prejudice the case. The totality of the circumstances may include, but is not limited to, the following: evidence is not yet available; the appellant was not represented at a lower level of appeal; the appellant was not aware of her rights; or the appellant did not understand the proceeding.

(b) Use of Patients' Medical Records.

Current Law. BIPA established QIC reconsiderations as part of the Medicare's administrative review process. To reconsider whether a service is reasonable and necessary, a QIC will employ panel of physicians or other appropriate health care professionals to review the facts and the circumstances of the initial determination. The QIC reconsideration is to be based on applicable information, including clinical experience, and medical, technical, and scientific evidence.

Explanation of Provision. Medical records of the individual involved in the appeal would be included as part of the applicable information used by QICs in their reconsideration process.

Effective Date. Upon enactment.

Reason for Change. In the determination of whether an item or service is reasonable and necessary for an individual, a beneficiary's medical records should be considered with other relevant information.

(c) Notice Requirements for Medicare Appeals.

Current Law. Section 521 of BIPA (which is not yet implemented) amends Section 1869 appeals process in its entirety, but did not establish specific notice requirements for each part of the Medicare appeals process.

Explanation of Provision. The provisions would establish that a written notice of an initial determination associated with a claims denial be provided. The notice would include: (1) the reason for the denial and, upon request, the specific policy, manual or regulation used to make the decision; (2) the procedures for obtaining additional information concerning the determination; and (3) notification of appeal rights and associated instructions.

The provisions would amend the existing requirement that a reconsideration decision be written and establish that the decision would have to be provided in printed form and written in a manner that could be understood by the beneficiary; the notice would include: as appropriate, a summary of the clinical or scientific evidence used to make the decision; upon request, the policy manual or regulation used to make the decision; and a detailed explanation of the decision to the extent appropriate. The requirement that the reconsideration decision include a notice of appeal rights and relevant instructions would also be established.

Comparable requirements would be extended to ALJ decisions. These decisions would have to be written in an understandable manner and include the specific reasons for the decision, an appropriate summary of the evidence, the procedures for obtaining additional information about the decision, and a notification of appeal rights and instructions.

The current requirements that a QIC prepare documentation and an explanation of the issues for an appeal to an ALJ would be modified: a QIC would be required to submit the information required in an appeal of a Medicare contractor's decision to the ALJ.

Effective Date. Upon enactment.

Reason for Change. Currently, Medicare only provides beneficiaries with a brief statement about the initial determination of her claim on the Medicare Summary Notice. This provision provides additional information to beneficiaries (or providers who appeal on their behalf) about Medicare's denial of their claim for benefits; the reasons for the denial, and the rights to further appeal so that

beneficiaries can have a clear and concise understanding of decisions affecting their medical care.

(d) Qualified Independent Contractors.

Current Law. BIPA established Qualified Independent Contractor (QIC) reconsiderations as part of Medicare's administrative review process. A QIC is an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations and that meets the established requirements for sufficient training and expertise in medical science and legal matters to make such reconsiderations. QIC reviews include consideration of the facts and circumstances by a panel of physicians or appropriate health professionals. No physician or health care professional employed by a QIC may review determinations regarding services provided to a patient, if directly responsible for furnishing the services to that patient. Review of home health care services is also prohibited by physicians and other professionals who have a significant direct or indirect financial interest in the agency or institution providing the care. This prohibition extends to physicians and professionals who have family members with such significant financial interests.

Explanation of Provision. To qualify as a QIC, an entity would be required to have sufficient medical, legal and other expertise, including knowledge of the Medicare program as well as sufficient professional qualifications, independence and staffing to make reconsideration decisions. A QIC would be required to assure that reviewers meet qualification and compensation requirements. If a reconsideration request indicates that a physician furnished the item or service, a reviewing professional should be a physician. Entities and their professional reviewers would have to meet independence requirements and may not: (1) be a related party; (2) have a material familial, financial, or professional relationships with a related party; or (3) have a conflict of interest with respect to a related party. QIC's compensation would not be contingent on any decision by the QIC or by any reviewing professional. A reviewer's compensation would not be contingent on any decision rendered by the reviewer. In this context, a related party to a Medicare case involving an individual beneficiary is (1) the Secretary, the Medicare administrative contractor involved, any fiduciary, officer, director or employee of HHS or such Medicare contractor; (2) the individual or authorized representative; (3) the health professional, institution or entity that provides or manufactures the item or service involved in the case; and (4) any other party with substantial interest in the case, as defined by regulation.

Individuals affiliated with a fiscal intermediary, carrier or other contractor would be able to act as a QIC reviewer if (1) a individual is not involved with the provision of the item or service of the case; (2) individual is not an employee of the Medicare contractor and does not provide services exclusively or primarily to or on behalf of the contractor; and (3) the fact of the relationship is disclosed to the Secretary and the Medicare beneficiary or authorized representative who do not

object. Individuals with staff privileges at the institution where treatment occurs would be able to serve as a reviewer if the affiliation is disclosed and there is no objection. Each reviewing professional shall be a allopathic or osteopathic physician or health care professional who is legally authorized to furnish items and services that are the subject of review in one or more states; and has medical expertise in the appropriate field for the case.

The provision would reduce the minimum number of QICs from twelve to a sufficient number, not fewer than four, to conduct reconsiderations consistent with established time frames for appeals.

Effective Date. As if included in BIPA.

Reason for Change. The BIPA 2000 law laid out broad provisions for revision of the Medicare appeals process. These provisions strengthen the appeals process by enhancing the criteria related to the independence and expertise of the reviewers and review entities.

Section 404. Prepayment Review.

Current Law. No provision.

Explanation of Provision. Medicare administrative contractors would be able to conduct random prepayment reviews in order to develop contractor-wide or program-wide claims payment error rates or under additional circumstances as established by regulations that are developed in consultation with providers and suppliers. Medicare administrative contractors would be permitted to conduct random prepayment reviews in accordance with a standard protocol developed by the Secretary. The Secretary would not be able to initiate non-random prepayment review based on the initial identification by a provider or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error. The Secretary would be required to issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment reviews. No provision would prevent the denial of payment for claims actually reviewed under random prepayment review. These provisions would be applied to fiscal intermediaries and carriers.

Effective Date. No later than one year from enactment. The Secretary would be required to issue regulations before that deadline; the random prepayment review protocols would apply to reviews after a date specified by the Secretary (but no later than one year from enactment.)

Reason for Change. These provisions build greater consistency and predictability into Medicare's rules for prepayment review, while protecting program integrity.

Section 405. Recovery of Overpayments

Current Law. No provision with respect to repayment plans. Section 1833(j) of the Social Security Act provides that interest accrues on underpayments or overpayments starting within 30 days of the date of the final determination of the accurate payment amount.

Explanation of Provision. Subject to certain qualifications, in circumstances where refund of an overpayment within 30 days would constitute a hardship, providers and suppliers on request would be allowed to repay the overpayment amount (by offset or otherwise) over a period of at least six months up to three years when their obligation exceeds a ten percent threshold of their annual payments from Medicare. The Secretary would be able to establish a repayment period of up to five years in cases of extreme hardship. Interest would accrue on the balance through the repayment period. The Secretary would be required to establish a process under which newly-participating providers and suppliers could qualify for a repayment plan under this hardship provision. Previous overpayment amounts already included in an ongoing repayment plans would not be included in the calculation of the hardship threshold. The Secretary would be allowed to seek immediate collection if payments are not made as scheduled. Exceptions to this provision would be permitted in cases where the Secretary has reason to suspect that bankruptcy may be declared or that the provider or supplier may otherwise cease to do business or discontinue participating in the Medicare program, or where fraud or abuse against Medicare is indicated. This provision would not affect the application of existing no-fault provisions which preclude recovery under certain circumstances where incorrect payment has been made to an individual who is without fault or where the recovery would decrease payments to another person who is without fault.

Upon enactment, the Secretary would not be able to initiate any recovery action if the provider or supplier has sought a reconsideration of the Medicare overpayment by a qualified independent contractor (QIC) until the date of the reconsideration decision. If QIC's are not yet in place, the recovery would not be initiated until the date of a redetermination decision by a fiscal intermediary or a carrier. If monies have been offset or repaid, the Secretary would return those amounts plus applicable interest if the original overpayment determination is reversed. If such an overpayment determination is upheld, interest would accrue beginning on the date of the original overpayment notice; the interest amount would be the rate otherwise applicable for Medicare overpayments.

Not later than one year after enactment, a Medicare contractor would not be able to use extrapolation to make overpayment determinations initiated after the date of enactment, unless, as determined by the Secretary, a sustained or high level of payment error exists or a documented educational intervention did not correct the payment error.

Where providers and suppliers have previously been overpaid, Medicare contractors would be able to require periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that a previous practice has been discontinued.

The Secretary would be able to use a consent settlement to resolve a projected overpayment. Before entering into any consent settlements after the date of enactment, the Secretary would be required to communicate to a provider or supplier that based on a preliminary evaluation of a medical records review, an overpayment may exist; the nature of the identified problems; and the necessary steps to address the problem. The Secretary would provide 45-days where additional information may be submitted concerning the claims for which the medical records have been reviewed. After considering the additional information, the Secretary would provide notice and explanation of any remaining overpayment determination and would offer the opportunity for a statistically valid random sample (which would not waive appeal rights) or a consent settlement (based on a smaller sample with a waiver of appeal rights) to resolve the overpayment amounts.

Not later than one year after enactment, the Secretary would be required to establish, in consultation with health care associations, a process where classes of providers and suppliers are notified that their Medicare contractor has identified specific billing codes that may be over-utilized.

For audits initiated after enactment, Medicare contractors would be required to provide a written notice (which may be in electronic form) of the intent to conduct a post-payment audit to those selected as audit candidates. Medicare contractors would be required to provide those who have been audited a full review and understandable explanation of the findings that: (1) permits the development of an appropriate corrective action plan; (2) provides information on appeal rights as well as consent settlements (which are at the discretion of the Secretary); and (3) provides for an opportunity to supply additional information to the contractor. Medicare contractors would be required to take into account the information provided on a timely basis. The provisions requiring notice of audit and findings would not apply if pending law enforcement activities would be compromised or findings of law enforcement-related audits would be revealed.

Not later than one year after enactment, the Secretary would be required to establish a standard methodology for Medicare contractors to use in selecting a claims sample for a review of abnormal billing patterns.

These provisions would apply to Medicare administrative contractors including fiscal intermediaries and carriers as well as those eligible entities with MIP contracts.

Effective Date. Upon enactment.

Reason for Change. These provisions build greater consistency and predictability into Medicare's rules for recovery of overpayments, while protecting program integrity.

Section 406. Provider Enrollment Process; Right of Appeal.

Current Law. Providers and, to some extent suppliers, have access to certain appeal mechanisms if their application to participate in Medicare is denied or terminated. Section 1866(h) of the Social Security Act provides for a hearing and for judicial review of that hearing for any institution or agency dissatisfied with a determination that it is not a provider (or that it can no longer be a provider). There is no statutory provision extending such judicial appeal rights to suppliers. Sections 1128(a) and (b) of the Act provide for the exclusion of certain individuals or entities because of the conviction of crimes related to their participation in Medicare; Section 1128(f) provides for hearing and judicial review for exclusions. In 1999, the Health Care Financing Administration (HCFA- now the Centers for Medicare and Medicaid Services or CMS) published a proposed regulation that would revise existing Medicare Part B administrative appeals procedures and extend them to all suppliers not currently covered.

Explanation of Provision. The Secretary would be required to (1) establish by regulation an enrollment process for providers and suppliers which would include deadlines for actions on enrollment applications within six months of enactment; (2) monitor the performance of Medicare administrative contractors in meeting the deadlines: (3) consult with providers and suppliers in making changes to the enrollment forms made on or after January 1, 2004. In establishing an enrollment process for providers and suppliers, the Secretary would build upon existing Medicare practice.

Providers and suppliers whose application to enroll or reenroll has been denied and who are dissatisfied with the determination would be entitled to a hearing and judicial review of the determination under the procedures that currently apply to providers. This provision would apply to denials after a date specified by the Secretary which could not be later than one year from enactment.

Effective Date. Upon enactment.

Reason for Change. This provision gives providers and suppliers an opportunity to appeal denials of their applications to participate in the Medicare program.

Section 407. Process for Correction of Minor Errors and Omissions Without Pursuing Appeals Process.

Current Law. No provision.

Explanation of Provision. The Secretary would be required to develop, in consultation with appropriate Medicare contractors and health care associations, a process where minor claims errors and omissions can be corrected and resubmitted without appealing the claims denial. In addition, a hospital may submit corrected or supplemented data for applications under 1886(d)(10)(C)(i)(II).

Effective Date. Upon enactment.

Reason for Change. Many of the providers and suppliers who testified before the Subcommittee or contacted members directly emphasized the need to create a process in which they could correct claims or other forms that were denied because they were incomplete or contained minor errors without having to pursue a formal appeal. This provision instructs the Secretary to create such a process, which will alleviate pressure on the appeals system. The Committee would be concerned, however, if this process were to become an incentive for providers to knowingly or negligently submit incomplete information.

The Committee intends that the process for correction of minor errors and omissions on claims cover both the submission of prepayment and post-payment review claims. For example, if in the case of a home health claim, the physician has signed the plan of care and/or physician's order but has not dated it, the claim shall be returned to the home health agency and may be resubmitted by the home health agency with any incomplete or missing information without having to appeal the claim. At the same time, past errors and omission in the data as part of applications under 1886(d)(10) (C) (i)(II) should not prevent a reexamination of the data in the normal application process given the significant financial consequences for any individual hospital.

Section 408. Prior Determination Process for Certain Items and Services; Advance Beneficiary Notices

Current Law. Medicare law prohibits payment for items and services that are not medically reasonable and necessary for the diagnosis or treatment of an illness or an injury. Under certain circumstances, however, Medicare will pay for non-covered services that have been provided if both the beneficiary and the provider of the services did not know and could not have reasonably been expected to know that Medicare payment would not be made for these services.

However, in most circumstances either the beneficiary or the provider will be liable in the event that Medicare does not cover an item or service. There are detailed rules on beneficiary and provider liability in the statute. A provider may be held liable for providing uncovered services, if, for example, specific requirements are published by the Medicare contractor or the provider

has received a denial or reduction of payment on the same or similar service. In cases where the provider believes that the service may not be covered as reasonable and necessary, the provider may limit his liability by providing an acceptable advance notice of Medicare's possible denial of payment to the patient. The notice must be given in writing, in advance of providing the service; include the patient's name, date and description of service as well as reasons why the service would not be covered; and must be signed and dated by the patient to indicate that the beneficiary will assume financial liability for the service if Medicare payment is denied or reduced. Currently, when there is a question about coverage, there is no way for a beneficiary or provider to find out in advance whether or not Medicare will cover that item or service for that particular beneficiary.

Explanation of Provision. The Secretary would be required to establish a process through regulation where physicians and beneficiaries can establish whether Medicare covers certain items and services before such services are provided. An eligible requestor would be either a physician or a Medicare beneficiary who receives an advance beneficiary notice (ABN) from a physician. Eligible items and services for review are those physicians' services under 1848(f)(4)(A) for which a physician may be paid directly. The provisions would establish: (1) such prior determinations would be binding on the Medicare contractor, absent fraud or misrepresentation of facts; (2) the right to redetermination in the case of a denial; (3) the applicability of existing deadlines with respect to those redeterminations; (4) contractors' prior determinations (and redeterminations) are not subject to further administrative or judicial review; and (5) an individual retains all rights to usual administrative or judicial review after receiving the service or receiving a determination that a service would not be covered. This section also requires that whenever a physician requests a pre-service determination (or redetermination), beneficiaries must still receive notices that include information explaining the beneficiary's right to receive the service and request access to the appeals process under section 1869. The calculation of the sustainable growth rate for physician updates is modified so that the increase in utilization from this provision is included. These provisions would not affect a Medicare beneficiary's rights in any future appeal or judicial action. The Secretary must establish the process to allow for the processing of such requests beginning 18 months after enactment. The Secretary would be required to collect data on the advance determinations and to establish a beneficiary and provider outreach and education program. GAO is required to report on the use of the advance beneficiary notice and prior determination process within 18 months of its implementation.

Effective Date. Upon enactment.

Reason for Change. The Committee believes that when there is a question of whether Medicare will cover certain care for a beneficiary, the beneficiary should have the right to find out what will be covered before getting the service and risking financial liability. Doctors also should be

able to make such a request on behalf of a particular patient. This provision is particularly important for seniors and disabled individuals who tend to be risk adverse and live on fixed incomes.

TITLE V - MISCELLANEOUS PROVISIONS

Section 501. Policy Development Regarding Evaluation and Management (E& M) Documentation Guidelines.

Current Law. No provision.

Explanation of Provision. The Secretary would not be permitted to implement any new documentation guidelines on or after enactment for evaluation and management (E&M) physician services unless the guidelines (1) are developed in collaboration with practicing physicians (both generalists and specialists) after assessment by the physician community; (2) based on a plan with deadlines for improving use of E&M codes; (3) are developed after completion of the pilot projects to test modifications to the codes; (4) are found to meet the desired objectives; and (5) are preceded the establishment of an appropriate outreach and education of the physician community. The Secretary would make changes to existing E&M guidelines to reduce paperwork burdens on physicians. The Secretary would be required to modify E&M guidelines to: (1) identify clinically relevant documentation; (2) decrease non-clinically pertinent documentation; (3) increase the reviewers' accuracy; and (4) educate the physicians and the reviewers.

The provisions would establish different pilot projects in specified settings that would be: (1) conducted on a voluntary basis in consultation with practicing physicians (both generalists and specialists); (2) be of sufficient length to educate physicians and contractors on E&M guidelines and (3) allow for an assessment of E&M guidelines and their use. A range of different projects would be established and include at least one project that (1) uses a physician peer review method; (2) uses an alternative method based on face-to-face encounter time with the patient; (3) is in a rural area; (4) is outside a rural area; and (5) involves physicians billing in a teaching setting and nonteaching setting. The projects would examine the effect of modified E&M guidelines on different types of physician practices in terms of the cost of compliance. Data collected under these projects would not be the basis for overpayment demands or post-payment audits. This protection would apply to claims filed as part of the project, would last the duration of the project., and would last for as long as the provider participated in the project. The Secretary, in consultation with practicing physicians including those in groups practices as well as generalists and specialists, would be required to evaluate the development of alternative E&M documentation systems with respect to administrative simplification requirements and report results of the study to Congress by October 1, 2005. The Medicare Payment Advisory Commission would conduct an analysis of the results of this study and submit a report to

Congress.

The Secretary would be required to conduct a study of the appropriate coding of extended office visits where no diagnosis is made and submit a report with recommendations to Congress no later than October 1, 2005.

Effective Date. Upon enactment.

Reason for Change. This provision is designed to promote greater consultation with practicing physicians with regard to the complicated evaluation and management and coding requirements governing Medicare payment for physician services.

Section 502. Improvement in Oversight of Technology and Coverage.

(a) Council for Technology and Innovation.

Current Law. No provision.

Explanation of Provision. The Secretary is required to establish a Council for Technology and Innovation within the Centers for Medicare and Medicaid Services (CMS). The council would be composed of senior CMS staff with an Executive Coordinator, who is designated or appointed by the Secretary and reports to the CMS administrator. The Chairperson would serve as a single point of contact for outside groups and entities regarding Medicare coverage, coding, and payment processes. The Council would coordinate Medicare's coverage, coding, and payment processes as well as information exchange with other entities with respect to new technologies and procedures, including drug therapies.

Effective Date. Upon enactment.

Reason for Change. CMS personnel responsible for coverage, coding and payment of medical innovation are often not well coordinated. This provision creates a focal point for technology and innovation within the Centers for Medicare and Medicaid Services by creating a Council to coordinate across the different Centers and Offices with responsibilities in this area. The Executive Coordinator also provides a single point of contact for outside groups, similar to recent initiatives launched by the Secretary for specific issues and types of providers.

(b) Methods For Determining Payment Basis for New Lab Tests.

Current Law. Outpatient clinical diagnostic laboratory tests are paid on the basis of area wide fee schedules. The law establishes cap on the payment amounts that is currently set at 74 percent of

the median for all fee schedules for that test. The cap is set at 100 percent of the median for tests performed after January 1,2001 that the Secretary determines are new tests for which no limitation amount has previously been established.

Explanation of Provision. The Secretary would be required to establish procedures (by regulation) for determining the basis and amount of payments for new clinical diagnostic laboratory tests. New laboratory tests would be defined as those assigned a new Health Care Procedure Coding System (HCPCS) code on or after January 1, 2005. The Secretary, as part of this procedure, would be required to: (1) provide a list (on an Internet site or other appropriate venue) of tests for which payments are being established in that year; (2) publish a notice of a meeting in the *Federal Register* on the day the list becomes available; (3) hold the public meeting no earlier than 30 days after the notice to receive public comments and recommendations; (4) take into account the comments, recommendations and accompanying data in both proposed and final payment determinations. The Secretary would set forth the criteria for making these determinations; make public the available data considered in making such determinations; and could convene other public meetings as necessary.

Effective Date. Upon enactment.

Reason for Change. The Secretary of Health and Human Services is required to establish by regulation an open process for any clinical diagnostic laboratory test. Under the regulations, the Secretary shall develop criteria for use in determining whether a laboratory test should be established through gap-filling or cross-walking to an existing code. When existing services are not sufficient and gap filling must be used, the criteria shall explain the basis of the data, the collection of the data, and the methodology for computing the rate. It is the view of the Committee that, in these cases, it is not appropriate for carriers or the agency to substitute the payment amount of an alternative test for the gap-fill amount.

The intent of Congress is to open the process to allow CMS to have access to information from beneficiaries, physicians, health care experts and laboratories. Using the information it receives through this new process, CMS shall develop and make available to the public the information used to arrive at a final determination. The information will include the rationale for each such determination, the data on which the determination is based, and responses to public comments.

Section 503. Treatment of Hospitals for Certain Services Under the Medicare Secondary Payor (MSP) Provisions.

Current Law. In certain instances when a beneficiary has other insurance coverage, Medicare becomes the secondary insurance. Medicare Secondary Payor is the Medicare program's coordination of benefits with other insurers. Section 1862(b)(6) of the Social Security Act

requires an entity furnishing a Part B service to obtain information from the beneficiary on whether other insurance coverage is available.

Explanation of Provision. The Secretary would not require a hospital or a critical access hospital to ask questions or obtain information relating to the Medicare secondary payor provisions in the case of reference laboratory services if the same requirements are not imposed upon those provided by an independent laboratory. Reference laboratory services would be those clinical laboratory diagnostic tests and interpretations of same that are furnished without a face-to-face encounter between the beneficiary and the hospital where the hospital submits a claim for the services.

Effective Date. Upon enactment.

Reason for Change. Hospitals would not have to directly contact each beneficiary on their retirement date, black lung status and other insurance information for reference laboratory services. While current law provisions for a claim containing valid insurance information are maintained, this provision is intended to reduce the amount of paperwork and regulatory burden related to the provision of these reference laboratory services by hospital-based entities.

Section 504. EMTALA Improvements.

Current Law. Medicare requires participating hospitals that operate an emergency room to provide necessary screening and stabilization services to a patient in order to determine whether an emergency medical situation exist prior to asking about insurance status of the patient.

Hospitals that are found to be in violation of EMTALA requirements may face civil monetary penalties and termination of their provider agreement. After a state investigation of an EMTALA complaint, the CMS Regional Office may ask their local peer review organization (PRO) to perform a 5-day review to obtain additional medical expertise. This review is discretionary. However, prior to imposing a civil monetary penalty, the Secretary is required to request that a PRO assess whether the involved beneficiary had an emergency condition that had not been stabilized and provide a report on its findings. Except in the case where a delay would jeopardize the health or safety of individuals, the Secretary provides 60-day period for the requested PRO review.

Explanation of Provision. Emergency room services provided to screen and stabilize a Medicare beneficiary furnished after January 1, 2004, would be evaluated as reasonable and necessary on the basis of the information available to the treating physician or practitioner at the time the services were ordered; this would include the patient's presenting symptoms or complaint and not the patient's principal diagnosis. The Secretary would not be able to consider the frequency with

which the item or service was provided to the patient before the time of admission or visit. The Secretary shall also not count the provision of the item or service during such an admission or visit when considering the frequency with which the item or service is furnished on subsequent occasions.

The Secretary would be required to establish a procedure to notify hospitals and physician when an EMTALA investigation is closed.

Except in the case where a delay would jeopardize the health and safety of individuals, the Secretary would be required to request a PRO review before making a compliance determination that would terminate a hospital's Medicare participation because of EMTALA violation. The current period of review for the discretionary review—5 business days—would apply for such review. The Secretary shall provide a copy of the report on its findings to the hospital or physician, consistent with existing confidentiality requirements. This provision would apply to terminations initiated on or after enactment.

Effective Date. Upon enactment.

Reason for Change. Providers have reported that some Medicare contractors are looking at final diagnoses (not presenting symptoms) in applying local medical review policies (LMRPs) that match particular tests to particular diagnoses-if a test does not match a listed diagnosis, payment is denied. Other claims are reportedly being denied based on LMRPs that set frequency limits for certain tests-if the test's use in the emergency room exceeds a frequency limit, payment is denied. In its January 2001 report entitled "The Emergency Medical Treatment and Labor Act: The Enforcement Process," the OIG recommended that CMS ensure that peer review occurs before a provider is terminated from the Medicare program for an EMTALA violation. This section implements that recommendation, making the current discretionary PRO review process mandatory in cases that involve a question of medical judgement.

Section 505. Emergency Medical Treatment and Active Labor (EMTALA) Technical Advisory Group.

Current Law. No provision.

Explanation of Provision. The Secretary would be required to establish a 19-member technical advisory group under specified requirements to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA). The advisory group would include: the CMS Administrator; the OIG; four hospital representatives who have EMTALA experience, (including one person from a public hospital and two of whom have not experienced EMTALA violations) seven practicing physicians with EMTALA experience; two patient representatives; two regional

CMS staff involved in EMTALA investigations; one representative from a State survey organization and one representative from a PRO. The Secretary would select qualified individuals who are nominated by organizations representing providers and patients.

The advisory group would be required to: (1) elect a member to as chairperson; (2) schedule its first meeting at the direction of the Secretary and meet at least twice a year subsequently; and (3) terminate 30 months after the date of its first meeting. The advisory group would review EMTALA regulations; provide advice and recommendations to the Secretary; solicit public comments from interested parties; and disseminate information on the application of the EMTALA regulations.

Effective Date. Upon enactment.

Reason for Change. In its January 2001 report entitled "The Emergency Medical Treatment and Labor Act: The Enforcement Process," the OIG recommended that CMS establish an EMTALA technical advisory group that includes all EMTALA stakeholders to help the agency resolve any emerging issues related to implementation of the law. Some of these current issues include specialists who refuse to service on call panels and inconsistencies between Stat and Federal law governing emergency medical services. In its June 2001 report entitled "Emergency Care: EMTALA Implementations and Enforcement Issues," the GAO also concluded that the establishment of a technical advisory group could help CMS work with hospitals and physicians to achieve the goals of EMTALA and avoid creating unnecessary burdens for providers. This section implements the OIG recommendation, establishing a 19-member technical advisory group within HHS.

Section 506. Authorizing Use of Arrangements to Provide Core Hospice Services in Certain Circumstances.

Current Law. Hospice programs are not permitted to use services provided under arrangement to deliver core hospice services. Under arrangement services are permitted for providers delivering Part A and Part B hospital services as well for skilled nursing services. However, the originating hospital or skilled nursing facility is required to bill for the service and be responsible for the quality of care delivered by the subcontractor

Explanation of Provision. Hospice programs may enter into arrangements with another certified hospice program to provide services. The provision for under arrangement services is limited to extraordinary or non-routine circumstances, such as unanticipated periods of staffing shortages. The originating hospice program continues to bear the legal responsibility for billing and maintaining quality of care.

In addition, hospice programs may make arrangements for highly specialized services of a registered professional nurse for non-routine and infrequent services that would be impracticable and prohibitively expensive to provide directly.

Effective Date. For hospice care provided after enactment.

Reason for Change. Hospice programs would be allowed to use personnel from other hospice programs to provide services to hospice patients. The program is given the flexibility so that a hospice program could continue to serve a patient if he or she was temporarily out of the area due to travel. Otherwise, the provision of the care to the patient might be delayed by the paperwork and requirements in starting up a new service at another agency. The program is also given the flexibility to arrange for highly specialized services of a registered professional nurse for non-routine and infrequent services that the hospice cannot reasonably provide directly. It is the intent of Congress that the originating hospice maintains control over the billing and quality of care.

Section 507. Application of OSHA Bloodborne Pathogens Standards to Certain Hospitals.

Current Law. Section 1866 establishes certain conditions of participation that providers must meet in order to participate in Medicare.

Explanation of Provision. Public hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 would be required to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations. A hospital that fails to comply with the requirement would be subject to a civil monetary penalty, but would not be terminated from participating in Medicare.

Effective Date. Applies to hospitals as of July 1, 2004.

Reason for Change. Last year, Congress enacted legislation that requires hospitals to utilize safe needles. However, that legislation only applies to non-government hospitals. Twenty-four states have similar requirements on public hospitals. This provision would protect the health and safety of health care workers in those facilities by requiring public hospitals in the other 26 states and the District of Columbia to comply with this important standard.

Section 508. BIPA-Related Technical Amendments and Corrections.

Current Law. BIPA established an advisory process for national coverage determinations where panels of experts formed by advisory committees could forward their recommendations directly to the Secretary without prior approval of the advisory committee or the Executive Committee.

Explanation of Provision. This provision makes technical corrections related to the Medicare Coverage Advisory Committee by transferring the provisions from Title 11 to Title 18 and by removing incorrect cross references to the establishment authority.

Effective Date. As if included in BIPA.

Section 509. Conforming Authority to Waive Program Exclusion.

Current Law. The Secretary is required to exclude individuals and entities from participation in Federal Health Programs who are (1) convicted of a criminal offense related to health care delivery under Medicare or under State health programs; (2) convicted of a criminal offense related to patient abuse or neglect under Federal or State law; (3) convicted of a felony relating to fraud, theft, or financial misconduct relating to a health care program financed or operated by the Federal, State or local government; or (4) convicted of a felony related to a controlled substance. At the request of a state, the Secretary is permitted to waive a program exclusion with respect to Medicare or Medicaid, but only for exclusions described in (1) above.

Explanation of Provision. The Administrator of a Federal health program would be permitted to request a waiver of a program exclusion if the exclusion of a sole community physician or source of specialized services in a community would impose a hardship. This conforming change would extend the same waiver authority currently in Medicare and Medicaid to federal health programs. In addition, waivers could be requested for Medicare, Medicaid, and federal health programs with respect to all exclusions except those related to patient abuse or neglect.

Effective Date. Upon enactment.

Reason for Change. This technical correction was requested by the Office of Inspector General.

Section 510. Treatment of Certain Dental Claims.

Current Law. Under current law, providers of services and suppliers submitting claims to Medicare must be enrolled in the Medicare program. However, certain services are specifically excluded from coverage under Medicare. Under current law, no payment may be made under part A or part B of the Medicare program for any services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except in the case of inpatient hospital services associated with the provision of these dental services if the individual's underlying medical condition and clinical status or the severity of the dental service require hospitalization.

Explanation of Provision. This provision would prohibit group health plans from requiring a

Medicare claims determination for dental benefits that are specifically excluded from Medicare coverage as a condition of making a determination for coverage under the group health plan. In so doing, this provision would ensure that dentists would not have to submit claims to the Medicare program (and thus enroll in the Medicare program) when the services they are providing are clearly those that are categorically excluded from coverage. In those cases that involve or appear to involve inpatient hospital services or dental services expressly covered by Medicare, a group health plan may require the claim to be first submitted to the Medicare program.

Effective Date. Sixty days after enactment.

Reason for Change. The Committee is concerned about private insurers requiring dentists to submit claims to Medicare for non-covered services before making a determination for coverage under the group health plan. Because of this requirement, dentists have been forced to enroll in the Medicare program to submit claims for services that are categorically excluded from Medicare coverage. Dentists view Medicare's enrollment application process as overly burdensome, particularly in light of the fact that most dental services are not covered by Medicare. This provision would alleviate the enrollment burden placed on dentists providing services clearly excluded from Medicare coverage, consistent with the overarching goal of this legislation to reduce regulatory burdens.

Section 511. Furnishing Hospitals with Information to Compute DSH Formula.

Current Law. No provision.

Explanation of Provision. The Secretary should furnish to hospitals the data necessary to compute the Medicaid days percentage on the Medicare cost report for the purposes of computing Medicare disproportionate share payments. It is the sense of this Committee that the Secretary has the flexibility to explore different models of dissemination of the data. For instance, in Arizona, the hospitals submit the data to the states for verification and the states forward it to the fiscal intermediaries.

Effective Date. 1 year after enactment.

Reason for Change. Hospitals have reported that it is difficult and expensive to verify their Medicaid days for use for Medicare inpatient payments. The Medicare program has experienced problems with improper payments being made due to the poor quality of the data.

S*ection 512. Miscellaneous Reports, Studies and Publication Requirements.*

(a) GAO Reports on Physician Compensation.

Current Law. No provision.

Explanation of Provision. No later than 6 months from enactment, GAO would be required to report to Congress on the appropriateness of the updates in the conversion factor including the appropriateness of the sustainable growth rate (SGR) formula for 2002 and subsequent years. The report would examine the stability and predictability of the updates and rate as well as the alternatives for use of the SGR in the updates. No later than 12 months from enactment, GAO would be required to report to Congress on all aspects of physician compensation for Medicare services. The report would review alternative physician payment structures, and provide recommendations to make the current system more stable and less complex.

Effective Date. Upon enactment.

Reason for Change. The Committee is soliciting expert feedback from GAO on ways to improve Medicare's complicated system of physician payment.

(b) Annual Publication of List on National Coverage Determinations

Current Law. No provision.

Explanation of Provision. The Secretary would be required to provide, in an annual report that will be publicly available, a list of Medicare's national coverage determinations made in the previous year and include information on how to learn more about such determinations.

Effective Date. Upon enactment.

(c) Report on Applying Home Health Conditions of Participation

Current Law. No provision.

Explanation of Provision. No later than 6 months from enactment, GAO would be required to report to Congress on the implications if there were flexibility in the application of Medicare conditions of participation for home health agencies with respect to groups or types of patients who are not Medicare beneficiaries. The report would include an analysis of the potential impact of flexible application on clinical operations and recipients of home health services, and analysis of methods for monitoring quality of care provided to patients.

Effective Date. Upon enactment.

Reason for Change. The Committee is soliciting expert review from GAO on implications of flexible application of the Medicare conditions of participation for home health agencies.

(d) Report on Notices Relating to Use of Hospital Lifetime Reserve Days

Current Law. No provision.

Explanation of Provision. No later than 1 year from enactment, the Inspector General would be required to submit a report to Congress on the extent to which hospitals provide notice to beneficiaries before they use their 60 lifetime reserve days, and the appropriateness of providing a notice to beneficiaries before they completely exhaust their lifetime reserve days.

Effective date. Upon enactment.

Reason for Change. The Committee is soliciting oversight on hospital compliance with requirements to notify beneficiaries about use of their 60 lifetime reserve days, and expert opinion on the appropriateness of a new notification requirement to inform beneficiaries before they exhaust their lifetime reserve days.

(e) Clarifications and Instructions to the Secretary

First, the Committee is pleased that the Secretary has published a notice of proposed rulemaking to provide Medicare payment for clinical psychology internship training programs that would not qualify under Medicare's existing provider-operated criteria. The Committee notes that Congress has consistently urged the Secretary to initiate payment for the training of clinical psychologists since 1997. Supportive language has been included in conference reports accompanying Medicare legislation in 1999 (Report 106-479), and in 2000 (Senate Report 106-293).

The Committee is concerned, however, that a delay in the rule may mean that hospitals and institutions will reduce or eliminate psychology training programs and urges implementation of the rule as soon as possible. The Committee notes that clinical psychologists provide valuable and unique services to Medicare beneficiaries during their training. Regarding their training, clinical psychologists are distinguishable from other health care professionals in that they are the only doctoral level mental health professionals fully participating in Medicare whose clinical training is not currently reimbursed. In addition, their clinical internship training is entirely controlled, administered, supervised, evaluated, and certified by the hospital or institution, separately accredited, and distinct from any university training they receive. Clinical psychologists are hospital-based in the final stages of their training functioning in a parallel status

to medical interns and residents, not medical nursing or health professional students. Where a clinical psychologist has clearly finished their educational curriculum and is training solely in the hospital setting, it is the intention of Congress that the hospital be reimbursed if that training is hospital-based.

Second, Congresses original intent on BIPA section 422(a)(2) on the dialysis composite rate has not been correctly interpreted by CMS. The intent was not to bar end stage renal disease (ESRD) composite rate exception relief for facilities that are not presently being paid under an exception to the composite rate. It is the Committee's expectation that CMS will evaluate ESRD composite rate exception requests submitted in 2002 and subsequent years by new renal dialysis facilities and existing facilities that do not have an exception.